

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT

Dates: Screen: / /

Assessment: 3 / 10/ 2004

Reassessment: 3 / 10/ 2005

IDENTIFICATION/BACKGROUND

Name & Vital Information

Client Name: Jones Addie T Client SSN: 000-00-02100
(Last) (First) (Middle Initial)
Address: 12100 Test Drive P.O. Box 777 Trainsville VA 12100
(Street) (City) (State) (Zip Code)
Phone: (999) 555-4446 City/County Code: Training Country:

Directions to House:

Pets?

Demographics

Birthdate: 9 /23/ 1931 Age: 74 Sex: Male 0 X Female 1
Marital Status: Married 0 X Widowed 1 Separated 2 Divorced 3 Single 4 Unknown 9
Race: White 0 X Black/African American 1 American Indian 2 Oriental/Asian 3 Alaskan Native 4 Unknown 9
Education: Less than High School X Some High School High School Graduate Some College College Graduate Unknown
Communication of Needs: X Verbally, English 0 Verbally, Other Language 1
Specify:
 Sign Language/Gestures/Device 2 Does Not Communicate 3
Hearing Impaired?
Ethnic Origin: Specify:

Primary Caregiver/Emergency Contact/Primary Physician

Name: Joe Smoe Relationship: Son
Address: Phone:(H)(999) 555-4446 (W)
Name: Relationship:
Address: Phone:(H) (W)
Name of Primary Physician: Phone:() - () -
Address:

Initial Contact

Who Called:
(Name) (Relation to Client) (Phone)

Presenting Problem/Diagnosis:

Current Formal Services

Do you currently use any of the following types of services?

| No 0 | Yes 1 | Check All Services That Apply | Provider/Frequency: |
|------|-------|--|---------------------|
| n/a | n/a | Adult Day Care | _____ |
| n/a | n/a | Adult Protective | _____ |
| n/a | n/a | Case Management | _____ |
| n/a | n/a | Chore/Companion/Homemaker | _____ |
| n/a | n/a | Congregate Meals/Senior Center | _____ |
| n/a | n/a | Financial Management/Counseling | _____ |
| n/a | n/a | Friendly Visitor/Telephone Reassurance | _____ |
| n/a | n/a | Habilitation/Supported Employment | _____ |
| n/a | n/a | Home Delivered Meals | _____ |
| n/a | n/a | Home Health Rehabilitation | _____ |
| n/a | n/a | Home Repairs/Weatherization | _____ |
| n/a | n/a | Housing | _____ |
| n/a | n/a | Legal | _____ |
| n/a | n/a | Mental Health (Inpatient/Outpatient) | _____ |
| n/a | n/a | Mental Retardation | _____ |
| n/a | n/a | Personal Care | _____ |
| n/a | n/a | Respite | _____ |
| n/a | n/a | Substance Abuse | _____ |
| n/a | n/a | Transportation | _____ |
| n/a | n/a | Vocational Rehab/Job Counseling | _____ |
| | | Other: _____ | _____ |

Financial Resources

Where are you on this scale for annual (monthly) family income before taxes?

| | |
|-----|---|
| n/a | \$20,000 or More (\$1,667 or More) 0 |
| n/a | \$15,000 - \$19,999 (\$1,250 - \$1,666) 1 |
| n/a | \$11,000 - \$14,999 (\$ 917 - \$1,249) 2 |
| n/a | \$ 9,500 - \$10,999 (\$ 792 - \$ 916) 3 |
| n/a | \$ 7,000 - \$ 9,499 (\$ 583 - \$ 791) 4 |
| n/a | \$ 5,500 - \$ 6,999 (\$ 458 - \$ 582) 5 |
| n/a | \$ 5,499 or Less (\$ 457 or Less) 6 |
| n/a | Unknown 9 |

Number in Family unit: _____

Optional: Total monthly family income: _____

Do you currently receive income from..

| No 0 | Yes 1 | Optional: Amount |
|------|-------|------------------------|
| n/a | n/a | Black Lung, _____ |
| n/a | n/a | Pension, _____ |
| n/a | n/a | Social Security, _____ |
| n/a | n/a | SSI/SSDI, _____ |
| n/a | n/a | VA Benefits, _____ |
| n/a | n/a | Wages/Salary, _____ |
| n/a | n/a | Other, _____ |

Does anyone cash your check, pay your bills or manage your business?

| No 0 | Yes 1 | Names |
|------|-------|-----------------------------|
| n/a | n/a | Legal Guardian, _____ |
| n/a | n/a | Power of Attorney, _____ |
| n/a | n/a | Representative Payee, _____ |
| n/a | n/a | Other, _____ |

Do you receive any benefits or entitlement

| No 0 | Yes 1 | |
|------|-------|---------------------------------|
| n/a | n/a | Auxiliary Grant |
| n/a | n/a | Food Stamps |
| n/a | n/a | Fuel Assistance |
| n/a | n/a | General Relief |
| n/a | n/a | State and Local Hospitalization |
| n/a | n/a | Subsidized Housing |
| n/a | n/a | Tax Relief |

What types of health insurance do you have?

| No 0 | Yes 1 | |
|------|-------|---------------------------------|
| n/a | n/a | Medicare, #: _____ |
| n/a | n/a | Medicaid, #: _____ |
| n/a | n/a | Medicaid pending? |
| n/a | n/a | QMB/SLMB? |
| n/a | n/a | All Other Public/Private: _____ |

Client Name: Addie T Jones

Client SSN:

000-00-02100

Physical Environment

Where do you usually live? Does anyone live with you?

| | Alone 1 | Spouse 2 | Other 3 | Names of Persons in Household |
|--|-----------------------------|----------|-------------------|------------------------------------|
| House: Own 0 | | | | |
| House: Rent 1 | | | | |
| House: Other 2 | | | | |
| X Apartment 3 | | | X | |
| Rented Room 4 | | | | |
| | Name of Provider (Place) | | Admission Date | Provider Number (If Applicable) |
| Adult Care Residence 50 | | | | |
| Adult Foster 60 | | | | |
| Nursing Facility 70 | | | | |
| Mental Health / Retardation Facility 80 | | | | |
| Other 90 | | | | |

Where you usually live, are there any problems?

| No 0 | Yes 1 | Check All Problems That Apply | Describe Problems: |
|------|-------|---|--------------------|
| X | _____ | Barriers to Access | |
| X | _____ | Electrical Hazards | |
| X | _____ | Fire Hazards/No Smoke Alarm | |
| X | _____ | Insufficient Heat/Air Conditioning | |
| X | _____ | Insufficient Hot Water/Water | |
| X | _____ | Lack of/Poor Toilet Facilities (Inside/Outside) | |
| X | _____ | Lack of/Defective Stove, Refrigerator, Freezer | |
| X | _____ | Lack of/Defective Washer/Dryer | |
| X | _____ | Lack of/Poor Bathing Facilities | |
| X | _____ | Structural Problems | |
| X | _____ | Telephone Not Accessible | |
| X | _____ | Unsafe Neighborhood | |
| X | _____ | Unsafe/Poor Lighting | |
| X | _____ | Unsanitary Conditions | |
| X | _____ | Other: _____ | |

Client Name: Addie T Jones

Client SSN:

000-00-02100

FUNCTIONAL STATUS (Check only one block for each level of functioning)

| ADL'S | Needs Help? | |
|----------------|-------------|-----|
| | No | Yes |
| Bathing | | X |
| Dressing | | X |
| Toileting | | X |
| Transferring | | X |
| Eating/Feeding | X | |

| MH Only 10 Mechanical Help | HH Only 2 Human Help | | MH & HH 3 | | Performed by Others 40 | Is Not Performed 50 |
|-----------------------------------|---|-----------------------|---------------------------------|------------------------------------|--|---------------------------|
| | Supervision 1 | Physical Assistance 2 | Supervision 1 | Physical Assistance 2 | | |
| | | | | X | | |
| | | X | | | | |
| X | | | | | | |
| X | | | | | | |
| | | | | | Spoon Fed 1 | Syringe/Tube Fed 2 |
| | | | | | | Fed by IV 3 |
| Incontinent Less than Weekly 1 | External Device/ Indwelling/ Ostomy Self Care 2 | | Incontinent Weekly or More 3 | External Device Not self care 4 | Indwelling Catheter Not self care 5 | Ostomy Not self care 6 |
| | | | | | | |
| | | | | | | |
| | | | | | | |

| Continence | Needs Help? | |
|------------|-------------|-----|
| | No | Yes |
| Bowel | X | |
| Bladder | X | |

Comments:

| Ambulation | Needs Help? | |
|---------------|-------------|-----|
| | No | Yes |
| Walking | | X |
| Wheeling | | X |
| Stairclimbing | | X |
| Mobility | | X |

| MH Only 10 Mechanical Help | HH Only 2 Human Help | | MH & HH 3 | | Performed by Others 40 | Is Not Performed 50 |
|-------------------------------|-------------------------|-----------------------|---------------|-----------------------|---------------------------|---------------------------------|
| | Supervision 1 | Physical Assistance 2 | Supervision 1 | Physical Assistance 2 | | |
| | | | | | | X |
| X | | | | | | |
| | | | | | | X |
| | | | | | Confined Moves About | Confined Does Not Move About |
| X | | | | | | |

Comments:

| IADL'S | Needs Help? | |
|------------------|-------------|-----|
| | No | Yes |
| Meal Preparation | | X |
| Housekeeping | | X |
| Laundry | | X |
| Money Management | | X |
| Transportation | | X |
| Shopping | | X |
| Using Phone | X | |
| Home Maintenance | | X |

Outcome: Is this a short assessment?

X No, Continue with Section 3 0 ___ Yes, Service Referrals 1 ___ Yes, No Service Referrals 2

Screener: _____

Agency: _____

PHYSICAL HEALTH ASSESSMENT

Professional Visits/Medical Admissions

| Doctor's Name(s) (List all) | Phone | Date of Last Visit | Reason for Last Visit |
|-----------------------------|-------|--------------------|-----------------------|
| | | | |
| | | | |
| | | | |

Admissions: In the past 12 months, have you been admitted to a... for medical or rehabilitation reasons?

| No 0 | Yes 1 | Name of Place | Admit Date | Length of Stay/Reason |
|------|-------|----------------------|------------|-----------------------|
| X | | Hospital | | |
| X | | Nursing Facility | | |
| X | | Adult Care Residence | | |

Do you have any advanced directives such as...(Who Has it...Where is it...)?

| No 0 | Yes 1 | Location |
|------|-------|--|
| | X | Living Will, _____ |
| X | | Durable Power of Attorney for Health Care, _____ |
| X | | Other, _____ |

Diagnoses and Medication Profile

Do you have any current medical problems, or a known or suspected diagnosis of mental retardation or related conditions, such as...(Refer to the list of diagnoses)?

| Current Diagnoses | Date of Onset |
|-------------------|---------------|
| | |
| | |
| | |

Enter Codes for 3 Major, Active Diagnoses:

None 00 19 DX1 23 DX2 6 DX3

| Current Medications (Include Over-the-Counter) | Dose,Frequency,Route | Reason(s) Prescribed |
|--|----------------------|----------------------|
| 1. _____ | | |
| 2. _____ | | |
| 3. _____ | | |
| 4. _____ | | |
| 5. _____ | | |
| 6. _____ | | |
| 7. _____ | | |
| 8. _____ | | |
| 9. _____ | | |
| 10. _____ | | |

Total No of Medications: 16 (If 0, skip to Sensory Function) Total No of Tranquilizer/Psychotropic Drugs: 1

- Diagnoses:**
- Alcoholism/Substance Abuse 01
 - Blood Related Problem 02
 - Cancer 03
 - Circulation 04
 - Heart Trouble 05
 - High Blood Pressure 06
 - Other Cardiovascular 07
 - Alzheimers 08
 - Non-Alzheimers Dementia 09
 - Mental Retardation 10
 - Autism 11
 - Cerebral Palsy 12
 - Epilepsy 13
 - Friedreich's Ataxia 14
 - Multiple Sclerosis 15
 - Muscular Dystrophy 16
 - Spina Bifida 17
 - Digestive/Liver/Gall Bladder 18
 - Diabetes 19
 - Other Endocrine Problems 20
 - Eye Disorders 21
 - Immune System Disorder 22
 - Arthritis/Rheumatoid Arthritis 23
 - Osteoporosis 24
 - Other Muscular/Skeletal Problem 25
 - Brain Trauma/Injury 26
 - Spinal Cord Injury 27
 - Stroke 28
 - Other Neurological Problems 29
 - Anxiety Disorders 30
 - Bipolar 31
 - Major Depression 32
 - Personality Disorder 33
 - Schizophrenia 34
 - Other Psychiatric Problems 35
 - Black Lung 36
 - COPD 37
 - Pneumonia 38
 - Other Respiratory Problems 39
 - Renal Failure 40
 - Other Urinary/Reproductive Problems 41
 - All Other Problems 42
 - None 43

| Do you have any problems with medicine(s)..? | | How do you take your medicine(s)? |
|--|-------|--|
| No 0 | Yes 1 | Without assistance 0 |
| X | | X Administered/monitored by lay person 1 |
| | X | Administered/monitored by professional nursing staff 2 |
| X | | Describe Help: _____ |
| | X | Name of Helper: _____ |
| | X | |

Sensory Functions

How is your vision, hearing, and speech?

| | No Impairment 0 | Impairment | | Complete Loss 3 | Date of Last Exam |
|---------|-----------------|---|-------------------|-----------------|-------------------|
| | | Record Date of Onset/Type of Impairment | | | |
| | | Compensation 1 | No Compensation 2 | | |
| Vision | | | | X | |
| Hearing | X | | | | |
| Speech | X | | | | |

Joint Motion: How is your ability to move your arms, fingers and legs?

- Within normal limits or instability corrected 0
- Limited motion 1
- Instability uncorrected or immobile 2

Have you ever broken or dislocated any bones...Ever had an amputation or lost any limbs...

Lost voluntary movement of any part of your body?

| Fractures/Dislocations | Missing Limbs | Paralysis/Paresis |
|---|---|---|
| <input type="checkbox"/> None 000 <input type="checkbox"/> Hip Fracture 1 <input checked="" type="checkbox"/> Other Broken Bone(s) 2 <input type="checkbox"/> Dislocations 3 <input type="checkbox"/> Combination 4 | <input type="checkbox"/> None 000 <input checked="" type="checkbox"/> Finger(s)/Toe(s) 1 <input type="checkbox"/> Arm(s) 2 <input type="checkbox"/> Leg(s) 3 <input type="checkbox"/> Combination 4 | <input type="checkbox"/> None 000 <input checked="" type="checkbox"/> Partial 1 <input type="checkbox"/> Total 2 Describe: _____ |
| Previous Rehab Program? <input type="checkbox"/> No/Not Completed 1 <input checked="" type="checkbox"/> Yes 2 | Previous Rehab Program? <input checked="" type="checkbox"/> No/Not Completed 1 <input type="checkbox"/> Yes 2 | Previous Rehab Program? <input checked="" type="checkbox"/> No/Not Completed 1 <input type="checkbox"/> Yes 2 |
| Date of Fracture/Dislocation <input type="checkbox"/> 1 Year or Less 1 <input checked="" type="checkbox"/> More than 1 Year 2 | Date of Amputation? <input type="checkbox"/> 1 Year or Less 1 <input checked="" type="checkbox"/> More than 1 Year 2 | Onset of Paralysis? <input type="checkbox"/> 1 Year or Less 1 <input checked="" type="checkbox"/> More than 1 Year 2 |

Nutrition

Height: _____ inches Weight: _____ lbs. Recent Weight Gain/Loss: No 0 Yes 1 Describe: _____

| Are you on any special diet(s) for medical reasons? | Do you have any problems that make it hard to eat? | |
|---|--|-------------------------------------|
| | No 0 | Yes 1 |
| <input type="checkbox"/> None 0 | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Low Fat/Cholesterol 1 | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> No/Low Salt 2 | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> No/Low Sugar 3 | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| <input checked="" type="checkbox"/> Combination/Other 4 | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Do you take dietary supplements? | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| <input checked="" type="checkbox"/> None 0 | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| <input type="checkbox"/> Occasionally 1 | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Daily, Not Primary Source 2 | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Daily, Primary Source 3 | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Daily, Sole Source 4 | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

Emotional Status

| In the past month, how often did you...? | Rarely/ Never 0 | Some of the Time 1 | Often 2 | Most of the Time 3 | Unable to Assess 9 |
|--|--------------------|-----------------------|---------|-----------------------|-----------------------|
| Feel anxious or worry constantly about things? | | | | X | |
| Feel irritable, have crying spells or get upset over little things? | | | X | | |
| Feel alone and that you didn't have anyone to talk to? | | | | X | |
| Feel like you didn't want to be around other people? | X | | | | |
| Feel afraid that something bad was going to happen to you and/or feel that others were trying to take things from you or trying to harm you? | | X | | | |
| Feel sad or hopeless? | | | | X | |
| Feel that life is not worth living...or think of taking your life? | X | | | | |
| See or hear things that other people did not see or hear? | | X | | | |
| Believe that you have special powers that others do not have? | X | | | | |
| Have problems falling or staying asleep? | | | X | | |
| Have problems with your appetite... that is, eat too much or too little? | | | X | | |

Comments:

Social Status

Are there some things that you do that you especially enjoy?

- | | | |
|------|-------|-----------------------------|
| No 0 | Yes 1 | Describe |
| ___ | X | Solitary Activities, _____ |
| ___ | X | With Friends/Family, _____ |
| X | ___ | With Groups/Clubs, _____ |
| X | ___ | Religious Activities, _____ |

How often do you talk with your children, family or friends, either during a visit or over the phone?

- | | | |
|-------------------------|-------------------------|----------------------------|
| Children | Other Family | Friends/Neighbors |
| ___ No Children 0 | ___ No Other Family 0 | ___ No Friends/Neighbors 0 |
| X Daily 1 | ___ Daily 1 | ___ Daily 1 |
| ___ Weekly 2 | ___ Weekly 2 | X Weekly 2 |
| ___ Monthly 3 | X Monthly 3 | ___ Monthly 3 |
| ___ Less than Monthly 4 | ___ Less than Monthly 4 | ___ Less than Monthly 4 |
| ___ Never 5 | ___ Never 5 | ___ Never 5 |

Are you satisfied with how often you see or hear from your children, other family and/or friends?

- X No 0 ___ Yes 1

Hospitalization/Alcohol - Drug Use

Have you been hospitalized or received inpatient/outpatient treatment in the last 2 years for nerves, emotional/mental health, alcohol or substance abuse problems?

No 0 Yes 1

| Name of Place | Admit Date | Length of Stay/Reason |
|---------------|------------|-----------------------|
| | | |
| | | |

Do (did) you ever drink alcoholic beverages?

Never 0
 At one time, but no longer 1
 Currently 2
How much: _____
How often: _____

Do (did) you ever use non-prescription, mood altering substances?

Never 0
 At one time, but no longer 1
 Currently 2
How much: _____
How often: _____

If the client has never used alcohol or other non-prescription, mood altering substances, skip to the tobacco question.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|------------------------|-------|--|------------------------------|------------------------------|--------------------|------------------------------|------------------------------|---------------|------------------------------|------------------------------|-------------------|--|------|-------|--|------------------------------|------------------------------|--------|------------------------------|------------------------------|--------|------------------------------|------------------------------|------------------|------------------------------|------------------------------|------------------|------------------------------|------------------------------|------------------------|
| <p>Have you, or someone close to you, ever been concerned about your use of alcohol/other mood altering substances?</p> <p><input type="checkbox"/> n/a <input type="checkbox"/> No 0 <input type="checkbox"/> n/a <input type="checkbox"/> Yes 1</p> <p>Describe concerns: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> | <p>Do (did) you ever use alcohol/other mood-altering substances with...</p> <table style="width: 100%;"> <tr> <td style="text-align: center;">No 0</td> <td style="text-align: center;">Yes 1</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/> n/a</td> <td style="text-align: center;"><input type="checkbox"/> n/a</td> <td>Prescription drug?</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/> n/a</td> <td style="text-align: center;"><input type="checkbox"/> n/a</td> <td>OTC medicine?</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/> n/a</td> <td style="text-align: center;"><input type="checkbox"/> n/a</td> <td>Other substances?</td> </tr> </table> <p>Describe what and how often: _____</p> <p>_____</p> <p>_____</p> | No 0 | Yes 1 | | <input type="checkbox"/> n/a | <input type="checkbox"/> n/a | Prescription drug? | <input type="checkbox"/> n/a | <input type="checkbox"/> n/a | OTC medicine? | <input type="checkbox"/> n/a | <input type="checkbox"/> n/a | Other substances? | <p>Do (did) you ever use alcohol/other mood-altering substances to help you...</p> <table style="width: 100%;"> <tr> <td style="text-align: center;">No 0</td> <td style="text-align: center;">Yes 1</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/> n/a</td> <td style="text-align: center;"><input type="checkbox"/> n/a</td> <td>Sleep?</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/> n/a</td> <td style="text-align: center;"><input type="checkbox"/> n/a</td> <td>Relax?</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/> n/a</td> <td style="text-align: center;"><input type="checkbox"/> n/a</td> <td>Get more energy?</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/> n/a</td> <td style="text-align: center;"><input type="checkbox"/> n/a</td> <td>Relieve worries?</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/> n/a</td> <td style="text-align: center;"><input type="checkbox"/> n/a</td> <td>Relieve physical pain?</td> </tr> </table> <p>Describe what and how often: _____</p> <p>_____</p> | No 0 | Yes 1 | | <input type="checkbox"/> n/a | <input type="checkbox"/> n/a | Sleep? | <input type="checkbox"/> n/a | <input type="checkbox"/> n/a | Relax? | <input type="checkbox"/> n/a | <input type="checkbox"/> n/a | Get more energy? | <input type="checkbox"/> n/a | <input type="checkbox"/> n/a | Relieve worries? | <input type="checkbox"/> n/a | <input type="checkbox"/> n/a | Relieve physical pain? |
| No 0 | Yes 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> n/a | <input type="checkbox"/> n/a | Prescription drug? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> n/a | <input type="checkbox"/> n/a | OTC medicine? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> n/a | <input type="checkbox"/> n/a | Other substances? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No 0 | Yes 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> n/a | <input type="checkbox"/> n/a | Sleep? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> n/a | <input type="checkbox"/> n/a | Relax? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> n/a | <input type="checkbox"/> n/a | Get more energy? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> n/a | <input type="checkbox"/> n/a | Relieve worries? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> n/a | <input type="checkbox"/> n/a | Relieve physical pain? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Do (did) you ever smoke or use tobacco products?

Never 0
 At one time, but no longer 1
 Currently 2
How much: _____
How often: _____

Is there anything we have not talked about that you would like to discuss?

5 Assessment Summary

Indicators of Adult Abuse and Neglect: While completing the assessment, if you suspect abuse, neglect or exploitation, you are required by Virginia law, Section 63.1-55.3 to report this to the local Department of Social Services, Adult Protective Services

Caregiver Assessment

Does the client have an informal caregiver?

X No 0 (Skip to Section on Preferences) Yes 1

Where does the caregiver live?

n/a With client 0

n/a Separate residence, close proximity 1

n/a Separate residence, over 1 hour away 2

Is the caregiver's help...

n/a Adequate to meet the client's needs? 0

n/a Not adequate to meet the client's needs? 1

Has providing care to the client become a burden for the caregiver?

n/a Not at all 0

n/a Somewhat 1

n/a Very much 2

Describe any problems with continued caregiving:

Preferences

Client's preferences for receiving needed care :

Family/Representative's preferences for client's care :

Physician's comments (if applicable):

Client Name: Addie T Jones

Client SSN:

000-00-02100

Client Case Summary

| | |
|--|--|
| | |
|--|--|

Unmet Needs

| No 0 | Yes 1 | | No 0 | Yes 1 | |
|----------|-------|---------------------------|----------|-------|---|
| <u>X</u> | _____ | Finances | <u>X</u> | _____ | Assistive Devices/ Medical Equipment |
| <u>X</u> | _____ | Home/Physical Environment | <u>X</u> | _____ | Medical Care/Health |
| <u>X</u> | _____ | ADLS | <u>X</u> | _____ | Nutrition |
| <u>X</u> | _____ | IADLS | <u>X</u> | _____ | Cognitive/Emotional |
| | | | <u>X</u> | _____ | Caregiver Support |

Assessment Completed By:

| Assessor's Name | Signature | Agency/Provider Name | Provider# | Section(s) Completed |
|-----------------|-----------|----------------------|-----------|----------------------|
| | | | | |
| | | | | |
| | | | | |

Optional: Case assigned to: _____ Code#: _____